

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

65-027588

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1 0425	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
2 20425				
3	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
4 1				
5 0	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
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7 0	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
8 2				
9 422.2	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
10				
11	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
12 86-2				
13 1-0	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 183

FILED AUG - 9 1965

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Henry	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clinton		c. CITY OR TOWN Clinton	
Length of stay in 1b 18 1/2 Months		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Clinton Nursing Home		d. STREET ADDRESS (If outside, give location) 306 E. Franklin	
3. NAME OF DECEASED (Type or print) First LELA Middle MAY Last JENNINGS		4. DATE OF DEATH Month July Day 29 , Year 1965	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1898
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Windsor, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Charles F. Jennings		13b. MOTHER'S MAIDEN NAME Joella Journey	
14. NAME OF HUSBAND OR WIFE none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT R. B. Jennings R. 4 Windsor, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis 352		INTERVAL BETWEEN ONSET AND DEATH Seconds	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary Edema 434.2		12 hours	
DUE TO (c) Myocardial Insufficiency 422.2		72 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Inanition + Debilitation - Congenital Cleft Palate		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1963 to July 29-65 and last saw her/him alive on July 29-65 Death occurred at 1:00 p.m. of the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) Clinton L. Gaspary		22b. ADDRESS Clinton, Mo	
22c. DATE SIGNED 7/31/65			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-31-1965	23c. LOCATION (City, town, or county) (State) Windsor Henry Mo.	
24. FUNERAL DIRECTOR ADDRESS Clifford Gouge Windsor, Mo.		25. DATE RECD. BY LOCAL REG. Aug. 7, 1965	
26. REGISTRAR'S SIGNATURE Mildred Bigman			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clifford Houge

Licensed Embalmer No. 5014

P. O. Address Windsor, Me.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.